



EAR & HEARING
Otolology | Neurotology | Audiology

Dear _____

Date: _____

Thank you for choosing **Dr. Abraham Jacob and Center for Neurosciences (CNS)** for your hearing healthcare! This letter breaks down a good faith estimate of costs associated with **Implantation of an Osteointegrating Device without Mastoidectomy – The Osia System – from Cochlear Americas.**

The Office Consultation

If your insurance company is contracted with CNS, we will bill your insurance for initial consultation with Dr. Jacob as well as any in-office procedures required as part of that visit. Copays, deductibles, and coinsurance may be collected at the time of visit.

If your insurance company is NOT contracted with CNS, Center for Neurosciences will collect a **\$500** consultation fee prior to seeing Dr. Jacob. **A credit card, cashier’s check, or cash are acceptable for payment. Unfortunately, we cannot accept personal checks.**

Surgical and Postoperative Care

All charges listed below are **private-pay**; CNS does not bill your insurance company since it has been determined that this operation, anesthesia, and surgical components are not covered by your insurance. Therefore, a signed waiver of insurance benefits will be obtained by CNS prior to the surgery as documentation.

| | |
|--|-------------------|
| Cochlear Osia Implant obtained from Cochlear Americas | \$ TBD |
| Tucson Medical Center Operating Room and Recovery Room Fees | \$ 3500.00 |
| Surgeon Fee + one postoperative office visit with CNS Staff | \$ 3200.00 |
| Anesthesia Fee | \$ 1500.00 |
| Audiology Fee for Device Activation | \$ 350.00 |
| | ----- |
| | \$ TBD |

Payment will be collected when surgery is scheduled, and a date is provided to you. If you elect to cancel surgery after it has been scheduled, \$1,500 is retained by CNS as a cancellation fee and the rest will be refunded. Please note that the above breakdown of costs **does not apply to revision surgery.**

Financial questions should be directed to the CNS Business Office (520) 795-7750. Dr. Jacob and his clinic staff will only handle questions related to your **medical care.**

Sincerely,

The Center for Neurosciences



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Osia System from Cochlear Americas:

I have read, understand, and agree to the contents of the letter above and agree that I will be liable for payment for services rendered by Dr. Jacob, the Center for Neurosciences, and Tucson Medical Center.

MY SIGNATURE BELOW ACKNOWLEDGES THAT:

- a. I have read (or had read/translated to me), understand and agree to the statements set forth in the above letter. I certify that there were no barriers to effective communication.
- b. A physician or physician's representative has explained to me all information referred to in the above letter. I have had an opportunity to ask questions and my questions have been answered to my satisfaction.
- c. No guarantees or assurances concerning the results of the surgery have been made.
- d. I am signing this consent voluntarily. I am not signing due to any threat, coercion, offer of payment or other influence.

Patient Name (print and sign)

Date

Witness Name (print and sign)

Date

Physician or Representative (print and sign)

Date